GIRL SCOUTS HEALTH HISTORY RECORD

ALL INFORMATION TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF GIRL ANNUALLY

PART I: GIRL RECORD

Girl's Name	School Attending	Birth Date	Troop Number
Address/City/State/Zip		Family E-Mail Address *(For GSNC use only)*	
Mother's Name	Day Time Telephone ( )	Evening Phone ( )	
Father's Name	Day Time Telephone ( )	Evening Phone ( )	

Is your girl/ward disabled? ☐ **NO** ☐ **YES** **If YES, does she need accommodation?** ☐ **NO** ☐ **YES**

Do we have your permission for your child/ward to receive emergency medical treatment if needed? ☐ **NO** ☐ **YES**

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health History Record** is for health care concerns at troop meetings and specified events. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent/Guardian Signature:______________________________ **Date:** ____________

In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to seek treatment for my child and/or dependent minor or myself by a licensed physician pursuant to California Family Code Section 6910 and California Civil Code Section 25.8. I know of no reason(s), other than the information indicated on this form, why my daughter/dependent or I should not participate in prescribed activities

Parent/Guardian Signature	Date	Telephone Number	Cell Phone Number

PART II: EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name	Relationship	Day Phone	Evening Phone
		( )	( )

PART III: HEALTH INSURANCE INFORMATION

Name of family DENTIST: ______________________ Telephone: ( ) ______________

Name of family PHYSICIAN: ______________________ Telephone: ( ) ______________

Family Medical/Hospital INSURANCE CARRIER: ______________ POLICY/GROUP NUMBER: ______________

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) ☐ **Check here for no known allergies**

☐ Animals__________ ☐ Hay Fever__________ ☐ Medicines/Drugs__________ ☐ Pollen__________
☐ Food__________ ☐ Insect Stings__________ ☐ Plants__________ ☐ Other (specify) __________

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates) ☐ Other Chronic/Recurring Illnesses (specify)__________

☐ Asthma __________ ☐ Diabetes__________ ☐ Heart Defect/Disease__________ ☐ Musculoskeletal Disorder__________
☐ Bleeding/Clotting Disorders__________ ☐ Ear Infection__________ ☐ Hypertension__________ ☐ Seizures__________

Date of last health examination:__________

Were any complicating medical problems noted in last health examination? ☐ NO ☐ YES If YES, what?__________

Other Health Conditions: (Check those that apply) ☐ Other (specify):__________

☐ Attention Deficit Disorder (ADD) ☐ Down's Syndrome ☐ Hearing Impairment ☐ Nose Bleeds ☐ Wears Glasses/Contacts
☐ Bed Wetting ☐ Emotional Disturbances ☐ Menstrual Cramps ☐ Sickle Cell Trait/Disease ☐ Special Dietary Regimen
☐ Dental Braces ☐ Fainting ☐ Motion Sickness ☐ Sleep Disturbances ☐ Visual Impairment

PART V: MEDICATION

Is your girl taking any medications? ☐ **NO** ☐ **YES**

If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS

Activity Restrictions? ☐ **NO** ☐ **YES**

If YES, list restrictions.

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PART VI: IMMUNIZATION HISTORY

☐ The following is my girl's immunization history:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P ………………………… (Diphtheria, tetanus and pertussis (whooping cough))		
Td ……………………………		
Measles………………………		
Mumps………………………		
Rubella (German measles)……		
Polio …………………………		
Hbpv …………………………		
Tuberculin Test (most recent)..	Result:	
Other (Specify):		

☐ **I/We have chosen not to immunize my/our girl.**

Parent/Guardian Signature Date

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Updated ______________________________ Date ______________

Updated ______________________________ Date ______________

Please review this form annually. If there are no changes or just minor adjustment, please mark those and then sign and date the form.